Medication Therapy Review
Patient Name or Identifier: _____ Date of Birth: _____
Pharmacist Name: _____

Medications (include herbals and nonprescription products):

Medication Name	Dose	Directions	Indication	Prescriber	Start Date	Stop Date	Comments

Lab Results (if known):

Date	Lab Test	Value	High/Low/Normal

Date	Lab Test	Value	High/Low/Normal